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ABSTRACT

This guide to alcohol and other drug abuse prevention for individuals with disabilities begins with a discussion of Congressional intent in enacting the Americans with Disabilities Act of 1990 (ADA), the stressful demands experienced by Americans with disabilities, and the ways in which these stresses may predispose people with disabilities to choose an escape through the use of alcohol or other drugs. The impact of the ADA on alcohol and drug prevention programs and professionals is outlined. The guide also examines the definition of a person with a disability, architectural and communication barriers, discrimination, suggestions to improve access and positive interactions, five commonly held myths about individuals with disabilities and the facts that dispel them, and language guidelines regarding people with disabilities. The guide concludes with a list of 13 organizational resources and 18 references. (JDD)

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A Look at Alcohol and Other Drug Abuse Prevention and...

AMERICANS WITH DISABILITIES

In the "Findings and Purposes" of the Americans with Disabilities Act (ADA) of 1990, Congress reported that approximately 43 million Americans have one or more physical or mental disabilities, and that this number is increasing as the population grows older. Congress referred to these people as a "discrete and insular minority who have been subjected to a history of purposeful, unequal treatment and relegated to an inferior status in our society." Congress further described the persistent discrimination experienced by people with disabilities in employment, housing, public accommodations, education, transportation, communication, recreation, institutionalization, health services, voting, and access to public services.

Congress reported that the severe disadvantages experienced by Americans with disabilities take many forms including:

- outright intentional exclusion;
- overprotective rules and policies;
- segregation or relegation to lesser services or programs;
- exclusionary standards; and
- architectural, transportation, and communication barriers

(Public Law 101-336, Section 2, July 26, 1990).

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The ADA was passed to address and eliminate the major forms of discrimination faced daily by people with disabilities. The Congressional findings are very important to alcohol and other drug prevention programs and professionals for another reason. They serve to illustrate that Americans with disabilities experience stressful demands. It is well known that most people with disabilities will experience some period of depression, denial, anger, grief, social isolation, agitation, and even guilt. There are also transition periods when a person may be dealing with issues of attribution. It could be the responsibility one has for having incurred a disability or chronic illness. Indeed, some may have contributed to the onset of their disability (e.g., by driving while intoxicated or smoking).

These stresses may predispose people with disabilities to choosing an escape through the use of alcohol or other drugs. Due to medical needs such as pain, spasticity, seizure control, or breathing difficulties, people with disabilities also have more ready access to prescription drugs. It is well documented that medical personnel, attendants, and family members sometimes enable the use and abuse of alcohol and other drugs by a person with a disability to alleviate their own guilt, provide a perceived pleasurable diversion, or simply avoid conflict.

Based upon five detailed case studies, de Miranda (1990) recently enumerated issues requiring additional attention by alcohol and other drug programs seeking to serve people with disabilities:

- The regular use of prescribed medication, both non-psychoactive and psychoactive, may serve to facilitate later legal or illicit drug use.
- Alcohol and other drug abuse that exists prior to disability acquisition tends to continue and worsen.

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- Accessing self-help groups such as Alcoholics Anonymous or Narcotics Anonymous is especially difficult for some people with disabilities.

The de Miranda study concluded that all of these circumstances provide a foundation for above average consumption of alcohol and other drugs.

These observations may partially explain (without approving or condoning) the real phenomenon that alcohol and other drug problems are significantly more prevalent among people with disabilities. Even though prevalence rates vary among specific disability groups, "There are reliable estimates of the incidence of alcohol and drug abuse among people with disabilities; indications are that it is at least double that of non-disabled people." (California Attorney General's Commission on Disability, 1989.) This is why the Office for Substance Abuse Prevention (OSAP) is looking at the alcohol and other drug abuse prevention issues unique to Americans with disabilities.

The ADA is important for alcohol and other drug prevention programs and professionals because of the potential impact on their operations and employment practices. The following needs to be noted:

1. Whether configured as a social service, health care service, or educational service, alcohol and other drug prevention programs are public accommodations. Beginning January 26, 1992, they must allow all people with disabilities to participate in the full and equal enjoyment of goods, services, facilities, privileges, advantages, and accommodations of the program.
2. While the ADA will outlaw the use of pre-employment medical examination, a drug test is not regarded as a medical examination for employment purposes. Accordingly, employers may test employees and applicants routinely either before or in the course of employment.
3. The ADA stipulates that people who are recovering from alcohol and other drug abuse may receive the full protection of the new law. Current users of illegal drugs or alcohol, however, receive no protections. The existence of another disability does not preclude discrimination clearly based on the current illegal drug or alcohol abuse.

These points serve to illustrate the increased importance of alcohol and other drug abuse prevention, especially in the workplace.

> "Attitudinal and architectural barriers to prevention and recovery for people with disabilities is oppression. Just as African-Americans were relegated to the back of the bus people with disabilities were, until the Americans with Disabilities Act, legally kept off the bus."
>
> **— Anthony Tusler**
> President
> Institute on Alcohol, Drugs and Disability

The employment provisions of the ADA prohibit discrimination in all employment-related practices and activities. They are rooted in the legislative history of Sections 503 and 504 of the 1973 Rehabilitation Act, but are much more far reaching. Additionally, there is much more awareness and involvement in the ADA by disability rights groups. The employment provisions become effective on July 26, 1992, and are expected to become rigorously enforced by the Equal Employment Opportunity Commission. Penalties for ADA employment discrimination, at a minimum, will include back pay, litigation expenses, and corrective action (e.g. hiring, reinstatement, promotion). In general, the public access provisions of the ADA become effective on January 26, 1992. They will be enforced by the Department of Justice, and civil penalties may reach $100,000 per violation.

The ADA, in conjunction with Section 504, is the most important civil rights legislation since the 1964 Civil Rights Act. It is leading to a major civil rights movement for Americans with disabilities, who have waited for decades to see their basic civil rights guaranteed by law.

OSAP has recognized the significance of the ADA and is attempting to facilitate the interface between the alcohol and other drug abuse prevention community and the disability and rehabilitation communities. A significant portion of the history of the 1990s will be written about the disability civil rights movement. You can participate in this important arena and even provide leadership. This begins by taking the necessary time to understand some basic information about disability.

Who are the 43 million Americans with disabilities? They are the largest and most diverse minority group in the U.S. Still, two-thirds of their working age members are unemployed even though 66% of these people say they want to work. According to the President's Committee on Employment of People with Disabilities, the cost to the American taxpayer is $300 billion annually. Worker compensation payments are over $25 billion per year, and one dollar of every hour of wages in America now goes for a disability related expense. Disability is an equal opportunity phenomenon, affecting every racial and economic segment of our population.

To fall within the Americans with Disabilities Act's (ADA) definition of a person with a disability, a person:

- must have a physical and/or mental impairment that substantially limits one or more major life activities; or
- must have a record of such an impairment; or
- must be regarded as having such an impairment.

This definition is broad by design and is intended to address both medical and psychosocial impediments to the full integration of Americans with disabilities.

The ADA defines as disabled people who have completely recovered from a disabling condition, but who have a history or record of disability. People with a history of cancer, heart surgery, or mental illness are common examples. The ADA also defines as disabled people who once had been misclassified as disabled (e.g., a person with a medication allergy who may have been wrongly diagnosed as epileptic). People who may be regarded as having a disability include:

- a person with hypertension that is controlled by medication, but whose employer has decided he or she cannot do strenuous work;
- a person with facial disfigurement that is disabling only because of the attitudes and reactions of others;
- a person who is rumored to carry the AIDS virus, but who has no impairment and is disabled only by the perception of others.

These people receive the full protection of the ADA, guaranteeing basic civil rights.

Architectural and Communication Barriers

The ADA recognizes that one significant barrier to the provision of alcohol and other drug abuse prevention services is the person's physical access to and within the place where such services are provided. Inaccessibility primarily affects those with mobility and sensory impairments, but it is relevant to many other disabled and even nondisabled people (e.g., pregnant women and elderly people). Title III of the ADA specifies that discrimination includes a failure to remove architectural or communication barriers in existing facili-

ties if such removal is readily achievable (i.e., accomplishable without much difficulty or expense). Examples would include modest adjustments such as adding grab bars in restrooms, lowering public telephones, or adding braille markings on elevator control buttons.

If the removal of a barrier is not readily achievable, then one must attempt to provide services or programs through alternate methods (e.g., providing assistance to retrieve items in an inaccessible location). The ADA mandates a much higher standard for "readily accessible to and usable by" regarding new construction and major alterations because it costs far less to design accessibility into a new construction project, typically adding 0.5% to 5% of the total budget.

Discrimination and Other Barriers

The lawmakers of the ADA were quick to recognize that the serious impediments to access for people with disabilities are not problems that can be solved solely by architects. They are problems of attitude. An attitudinal barrier is defined as a way of thinking or feeling that results in behavior which limits the potential of people with disabilities to function independently. Attitudes toward people with disabilities have been explored. Three important assumptions can be noted:

1. A small percentage of people have openly negative attitudes that are associated with prejudice, fear, ignorance, intolerance, insensitivity, discrimination, dislike, condescension, and the like. They subscribe to most of the myths surrounding disabilities, even in the face of documented evidence to the contrary.
2. The vast majority of the American public is neither positive nor negative toward people with disabilities. Their general reaction is one of massive and deliberate indifference. They just prefer not to think about disability at all.
3. This indifference is rooted in a perfectly natural psychological phenomenon in which, when we think about or encounter disability, we must think about and deal with the fragility of our own health and ultimately our own mortality. To do so is unpleasant and uncomfortable for most people.

Avoiding this discomfort has been too expensive. Any indifference, unpleasantness, or discomfort felt, any attitudinal barriers that may have been erected around the issue of disability must be removed. As in all areas of life, complete access to alcohol and other drug abuse prevention services must be guaranteed.

Suggestions to Improve Access and Positive Interactions

Offer assistance if you wish, but do not insist. Always ask before you act, but do not help without permission. If you are not sure what to do, ask the person to explain what would be helpful.

Focus on the abilities of the person, rather than on the disability. Be mindful that alternative ways of doing things are often equally effective. Encourage people with disabilities to be their own advocates.

Be aware of limitations specific to a disability, but do not be overprotective. Do not exclude the person from participating in an activity just because you assume their disability would be a problem. Let them make the decision; do not lower your expectations. There is dignity in being able to take risks. Allow a person with a disability to fail just as you would allow any other person. No one succeeds all the time.

Make sure that parking areas, restrooms, and buildings in which you provide services or conduct meetings are architecturally and environmentally accessible to all people. This is crucial

to the establishment of a comfortable and equitable relationship with people with a disability. Get expert advice before making expensive structural modifications.

Accessibility to the full range of services you provide is legally required. Review your programs and reading materials. Are they diverse enough to reach all levels of ability? Is the content accessible to people with hearing, visual, or learning disabilities? (e.g., audiotapes, audiovisuals, large print).

Conduct outreach efforts to publicize your programs to people with disabilities. Allow time for them to become fully aware of your services and develop trust in your efforts.

Ask a person with a disability to facilitate disability awareness training sessions with staff to promote positive attitudes. Locate material and have it available for learning more about disability related issues.

Involve people with disabilities on advisory boards, planning committees, in positions of authority and in the planning and presentation of all sponsored programs. Actively seek qualified persons with disabilities when hiring for staff positions.

Assume responsibility for understanding the issues that affect people with disabilities. Learn more. Send for information from consumer and disability related organizations, ask for their support, and invite their representatives to speak at meetings.

For each person with a disability, explore all possible factors contributing to alcohol and other drug involvement, not just those related to disability.

The Power of Language

It is important to monitor your use of written and spoken language regarding people with disabilities. Words are powerful tools, indicating the perceptions and attitudes of the person using them. The following general guidelines will be helpful:

1. Focus on issues and not on a disability. Above all, do not sensationalize a disability by using terms such as "afflicted with," "suffers from," "victim of," "shut-in," "infirmed," "crippled with," or "unfortunate." These expressions are very offensive, even defamatory, to people with disabilities.
2. Emphasize people, not generic labels. Say "people with mental retardation," not "the retarded." Put people first, not their disability.
3. Emphasize abilities, not limitations. Say "uses a wheelchair," not "confined to a wheelchair" or "wheelchair bound."
4. Avoid condescending euphemisms like "handicapped, mentally different, physically inconvenienced, physically challenged." These tend to trivialize disabilities and suggest that they cannot be dealt with in an upfront manner.
5. Avoid disease connotations such as "patients" or "cases."

MYTHS & **FACTS**

MYTH: *Disability is a constantly frustrating tragedy.*

FACT: People with disabilities do not sit around and ponder their disability all the time. They simply carry out their lives as normally as they can.

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MYTH: *People with disabilities have interests, needs, desires, abilities, and lifestyles which are profoundly different from other people.*

FACT: People with disabilities are more like than unlike people without disabilities in all respects. As with all of us, it is their unique individuality that makes each person different.

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MYTH: *If a person with a disability has a problem with alcohol or other drugs, it probably began as a result of the disability.*

FACT: Many people with disabilities have pre-disability histories of alcohol or other drug involvement. In the case of trauma, for example, about 50% of all injuries involve the use of alcohol or other drugs. People with disabilities experience the same risk factors as others, including possible hereditary predispositions. These may have more impact on alcohol and other drug use than disability related issues per se.

MYTH: *People with disabilities prefer to work with alcohol and other drug abuse prevention personnel who are disabled.*

FACT: People with disabilities seek services from professionals who are the most qualified in their areas in terms of training, experience, knowledge of resources, and willingness to work with disability issues.

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MYTH: *People with disabilities prefer separate programs and services.*

FACT: Most people with disabilities do not want or need separate programs which often limit opportunities and perpetuate segregation and the myth of "different-ness." Besides, the ADA expressly prohibits the provision of separate services "unless such action is necessary to provide a service that is as effective as that provided to others."

REMEMBER

ASK AND LISTEN!

A person with
a disability
is the expert
about his or her
disability.

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For More INFORMATION

Organizations

Include, but are not limited to, the following:

Adaptive Environments Center
374 Congress Street, Suite 301
Boston, MA 02210
(617) 695-1225 Voice and TDD

Association for Persons with Severe Handicaps
11202 Greenwood Avenue, North
Seattle, WA 98133
(206) 361-8870
(206) 361-0119 TDD

Barrier Free Environments, Inc.
PO Box 30634
U.S. Highway 70, West Water Garden
Raleigh, NC 27622
(919)782-7823

National Council on Independent Living
Troy Atrium, 4th Street and Broadway
Troy, NY 12180
(518) 274-1979
(518) 274-0701 TDD

National Easter Seal Society
70 East Lake Street
Chicago, IL 60601
(800) 221-6827
(312) 726-4258 TDD

National Rehabilitation Information Center
8455 Colesville Road, #935
Silver Spring, MD 22091
(800) 34-NARIC Voice and TDD

Government Agencies

Architectural and Transportation Barriers Compliance Board
111 18th Street, NW
Suite 501
Washington, DC 20036
(202) 653-7834 Voice and TDD

National Institute on Disability and Rehabilitation Research
U.S. Department of Education
400 Maryland Avenue, SW
Washington, DC 20202
(202) 732-1134 (202) 732-5316 TDD

National Council on Disability
800 Independence Avenue, SW, Suite 814
Washington, DC 20591
(202) 267-3235 (202) 267-3232 TDD

President's Committee on Employment of People with Disabilities
1331 F Street, NW, Suite 300
Washington, DC 20004
(202) 376-6200 (202)376-6205 TDD

Rehabilitation Services Administration
U.S. Department of Education
330 C Street, SW
Washington, DC 20001
(202) 732-1282

Community Contacts

Many of the listed organizations have state and local chapters.

To locate additional resources contact your state Governor's Committee of People with Disabilities

or obtain a State Resource Sheet from

National Information Center for Children and Youth with Disabilities
PO Box 1492
Washington, DC 20013
(703) 893-6061 (800) 999-5599 (703) 893-8614 TDD

References

Boros, A. (1989). Facing the challenge. *Alcohol Health and Research World*, 13(2): 101-103.

Coalition on Disability and Chemical Dependency (1989). The California alcohol, drug and disability study final report, Vol. 1, July 1989.

de Miranda, J. (1990). The common ground? Alcoholism, addiction and disability. *Addiction and Recovery*, 42-45.

Dufour, M.C., Bertolucci, D., Cowell, C., Stinson, F.S., and Noble, J. (1989). Epidemiologic bulletin No. 21 - Alcohol-related morbidity among the disabled: The Medicare experience 1985. *Alcohol Health and Research World*, 12(2), 158-161.

Greer, B.G. (1989). Alcohol and other drug abuse by the physically impaired: A challenge for rehabilitation educators. *Alcohol Health and Research World*, 13(2), 144-149.

Greer, B.G. (1990). Substance abuse among clients with other primary disabilities: Curricular implications for rehabilitation education. *Rehabilitation Education*, 4, 33-34.

Hepner, R, Kirshbaum, H, and Landes, D. (1980/81). Counseling substance abusers with additional disabilities: Center for independent living. *Alcohol Health and Research World*, 5(2), 11-15.

Hopkins, M.T. (1971). Patterns of self-destruction among the orthopedically disabled. *Rehabilitation Research and Practice Review*, 3(1), 5-16.

Betts, Henry B., and Richmond, Julius B. (1991). Disability in America report. Institute of Medicine, the Centers for Disease Control, and the National Council on Disability. Washington, DC.

Harris 1986 Survey of Disabled Americans,(1986). Louis Harris and Associates (Producer), Study #85-409 conducted by Louis Harris and Associates for ICD - International Center for the Disabled; New York, NY.

Kawaguchi, R., and Butler, E.W. (1982). Impairments and community adjustment of young adults: Alcohol use, drug abuse and arrest. *Chemical Dependency*, 4(3), 209-219.

Moore, D., and Siegal. H. (1989). Double trouble: Alcohol and other drug use among orthopedically impaired college students. *Alcohol Health and Research World*, 13(2), 118-123.

National Center for Medical Rehabilitation Research (1991). The scope of physical disability in America-the populations served. National Institute of Child Health and Human Development, U.S. Department of Health and Human Services, Bethesda, MD.

Rasmussen, G.A., and DeBoer, R.P. (1980/81). Alcohol and drug use among clients at a residential vocational rehabilitation facility. *Alcohol Health and Research World*, 5(2), 48-56.

Regional Rehabilitation Research Institute on Attitudinal, Legal and Leisure Barriers (1979). *The Invisible Battle: Attitudes Toward Disability*. George Washington University, Washington, DC, April. 1979.

Task Force on Medical Rehabilitation Research (1990). Report of the task force on medical rehabilitation research. National Institute of Health, U.S. Department of Health and Human Services, Bethesda, MD.

U.S. Congress. Americans with Disabilities Act of 1990. 101st Congress Public Law 101-336, July 26, 1990.

Wisconsin Department of Health and Social Services, Office for Persons with Physical Disabilities. (1985). Alcohol use by persons with disabilities: Preliminary report. Wisconsin Department of Health and Social Services, Madison, WI.

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Resource Center on Substance Abuse Prevention and Disability ▪ 1331 F Street N.W., Suite 800 ▪ Washington, DC 20004
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